DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: ProMedica Nursing and Rehab Pike Creek **DATE SURVEY COMPLETED: May 12, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced semi-annual and complaint survey was conducted at this facility from May 3, 2022 through May 12, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 89. The survey sample totaled 39 residents.		
3201.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross refer to CMS 2567-L survey completed May 12, 2022: F558, F580, F626, F657, F684, F761, F806, F810, F812, and F842.		

Provider's Signature _____ Title NHA Date 6/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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E 000	Initial Comments An unannounced emergency preparedness survey was conducted at this facility from May 3, 2022 to May 12, 2022 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 89. For the Emergency Preparedness survey, all contracts, operations plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced semi-annual and complaint survey was conducted at this facility from May 3, 2022 through May 12, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 89. The survey sample totaled 39 residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; CM - Care Manager; DON - Director of Nursing; FM - Family Member; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RD - Registered Dietitian; RDO - Regional Director of Operations; RN - Registered Nurse;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/15/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 RP - Responsible Party; SW - Social Worker; UM - Unit Manager. BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment cc (cubic centimeter) - unit of volume; COVID-19/Coronavirus - a respiratory illness that can be spread person to person; Hemodialysis / Dialysis - a process of filtering and removing waste products from the bloodstream; MDS - Minimum Data Set - standardized set of assessments completed in nursing homes; Sacrum - tailbone; TPN - (Total Parental Nutrition) - medical term for infusing a specialized form of food through a vein (intravenously). The goal of the treatment is to correct or prevent malnutrition;	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure a call bell was in reach for one (R55) out of 89 residents reviewed. Findings include:	F 558	F558 Reasonable Accommodations of Needs/Preferences It is the practice that all residents who reside in the facility receive services with	6/30/22

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F 558	Continued From page 2 During an observation on 5/3/22 at 9:58 AM, R55 was observed in bed wearing a gown that was visibly soiled with a soft brown odorous substance indicative of bowel movement. R55's call bell was out of reach and clipped to R55's bed. The surveyor activated the call bell and at 10:01 AM E12 (CNA) responded to the call bell and confirmed that R55's call bell was out of reach. During an observation on 5/3/22 at 11:46 AM, R55 was observed in bed and the call bell was on the floor underneath R55's roommates bed. E10 (RN) confirmed the finding and reported she would place it within R55's reach. Findings were reviewed with E2 (DON) on 5/10/22 at 1:15 PM.	F 558	reasonable accommodation of resident needs and preferences. I Corrective Action Patient R55□s call bell was immediately placed within patients reach and Patient R55 care plan was updated that patient will throw call bell if attached to bed; place call bell in bedside table or hang on bedside drawer. II Identification Current patient□s residing in the facility will be audited to validate call bell is within reach and if patient□s are identified with preferences on call bell placement their care plan will be updated. III Systemic Changes The Director of Nursing or designee will provide re-education to all current staff on call light procedure specifically that the call bell is within reach. The root cause of the deficiency is that patient had preferences on placement of his call bell and it was not captured on the care plan. IV Monitoring Director of Nursing or designee will conduct random audits to current patients residing in facility to validate that patient□s call bell is within reach. Monitoring will be conducted weekly x times 3 weeks until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality	

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F 558	Continued From page 3	F 558	Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		6/30/22

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F 580	Continued From page 4 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy and procedure, it was determined that for one (R440) out of eight (8) residents reviewed for accident investigations, the facility failed to promptly notify R440s court appointed guardian (C1) when R440 had an unwitnessed fall which resulted in injury and required physician intervention. Findings include: Review of the facility's written guidance titled Change of Condition, dated 11/16, stated, "...CMS requires a facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: An accident involving the resident which results in injury and has the potential for requiring	F 580	F580 Notify of Changes It is the practice of the facility to inform the patient, consult with the patient physician and notify the patient representative consistent with patient□s authority when there is a fall. I Corrective Action Patient R440 no longer resides at the facility. II Identification A review of all patients who had a fall within the last 30 days were audited to validate that the patient representative was notified. Patient facesheets were	

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F 580	Continued From page 5 physician intervention...". Cross refer F842, Example #3. 7/26/16 - R440 was admitted to the facility. 6/6/18 - C1 became the court appointed guardian for R440. 2/7/22 - The facility's incident report stated R440 had an unwitnessed fall from the bed to the floor on 2/7/22 at approximately 11:30 PM and R440's family member (FM1) was notified on 2/8/22 at 12:30 AM. FM1 is not the court appointed guardian. 2/7/22 23:30 PM - A Progress Note by E25 (RN) documented that R440 had swelling of her right foot and a physician's order was received for a cold compress and pain medication. There was lack of evidence that C1, R440's court appointed guardian was notified regarding the accident which required physician intervention. 2/8/22 6:43 AM - A Progress Note by E5 (LPN) documented that R440's family member FM1 was notified of R444's unwitnessed fall. FM1 is not the court appointed guardian. 2/8/22 10:56 AM - A Progress Note documented that the results of the x-ray of the left leg confirmed a fracture and an order was obtained to transfer R440 to the emergency room. The note documented that C1 (court appointed guardian) was telephoned, however, there was no answer, thus, FM1 was telephoned and obtained approval to transfer R440 to the hospital.	F 580	reviewed to validate the accurate authorized patient representatives was documented. No issues were noted, but if corrections need to be made patient□s face sheet will be updated by Social Services or designee. III Systemic Changes Director of Nursing or designee will re-educate all current licensed nurses on Change in Condition Procedure ensuring that patient representatives authorized by the patient are notified upon a patient□s fall and that the notification is documented in the patient chart. The root cause of the deficiency was there was a gap in knowledge related to staff documentation of the notification of authorized representative when there is a fall. IV Monitoring The Director of Nursing and/or designee will monitor patients who fall to ensure that patient representatives are notified by facility. Monitoring will be conducted weekly x 3 weeks until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine	

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F 580	Continued From page 6 2/8/22 5:24 PM - A Concern Form was completed by E4 (RN UM) which stated that R440's guardian (C1) called the facility and was upset that she was not notified of R440's status as she was the first contact. Follow-up by the facility stated that E5 attempted to call C1 first, was unable to leave a message and proceeded to contact FM1, who was next on the list of emergency contacts. 5/11/22 1:43 PM - An interview with E5 (LPN) revealed for the 2/7/22 fall, E5 telephoned the guardian C1, however, E5 was unable to contact C1, and proceeded to contact (FM1), R440's son. The Surveyor informed E5 there was lack of evidence that an attempt to contact R440's guardian C1 was made. E5 stated that she completed a progress note afterwards to show that she attempted to contact C1. The Surveyor responded there was a Progress Note dated 2/10/22 and timed 12:22 AM, stating, "Call first contact (Name of R440's court appointed guardian's, C1), no answer." E5 stated this was the note related to the 2/7/22 unwitnessed fall, although there was no reference in the note to the 2/7/22 fall. The facility failed to have evidence of notifying R440's guardian, C1 when R440 had an unwitnessed fall. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 580	the need for further monitoring and/or action plans.	
F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility.	F 626		6/30/22

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F 626	Continued From page 7 A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R444) out of four residents reviewed for discharge, the facility failed to ensure R444 was readmitted to the facility or	F 626	It is the practice that the facility permits residents to return to facility. I Corrective Action- R444 was discharged on 1/3/21 to the	

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F 626	Continued From page 8 that the facility complied with requirements as they apply to discharges. R444 was sent to the hospital on 1/3/21 and remained there at the time of survey exit, greater than 365 days. Additionally, the facility failed to establish a written policy on permitting residents to return to the facility after hospitalization. Findings include: Review of the facility policy entitled "Interdisciplinary Care Transition Checklist", last updated April 2022, the "Transition from skilled nursing facility to acute care" section lacked evidence of a policy on permitting residents to return to the facility after discharge. Review of the facility policy for transfer/discharge notices, last revised August 2019, indicated, "When a patient is transferred out of the facility, the facility must provide certain notices including a transfer discharge notice." Review of R444's clinical record revealed: 12/21/20 - A care plan was created that indicated R444 did "not show potential for discharge to community, care needs will continue to be met at facility. Reassess care needs and potential for discharge as needed, support patient and or family representative as needed." 1/3/21 8:10 AM - A progress note documented, "Called NP and received orders to send [R444] to ER (Emergency Room) for evaluation, due to patients behaviors... staff member with patient at time of incident and staff member yelled for help with patient. 911 called and guardian [made] aware. [R444] presently sitting in a chair. Awaiting 911...Staff member present with [R444]. Administrator aware."	F 626	hospital related to acute change in condition evidenced by R444□s endangerment of other individuals in the facility including staff. Based on this, the facility is unable to meet the welfare and needs and did not permit R444 to return to the facility. On 6/22/22, R444□s guardian was provided a Notice of Discharge based on the facilities inability to care for R444 and the facility remains unable to care for the patient due to the closure of the secured memory care unit. II Identification The Administrator or Designee audited current patients who were discharged in the last 30 days to validate that patient who were discharged to the hospital were permitted to return to the facility. III System Changes- The Administrator or designee will re-educate facility interdisciplinary team on the facilities Transfer/Discharge Notification Practice specifically that we are permitting residents to return to the facility after hospitalization and if appropriate, the patient will resume residence while an appeal process is pending. The Root Cause is that at the time of the discharge on 1/3/2021 the facility failed to execute the steps necessary to notify the resident and ombudsman that R444 was an endangerment to the safety of other individuals and the facility was unable to meet the needs of R444 and allow R444 to reside in the facility while the appeal process is pending. IV Monitoring- Administrator or designee will monitor	

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F 626	Continued From page 9 1/3/21 - An MDS assesment for discharge return anticipated was completed for R444 that documented no discharge plan and that no referral was needed. 1/3/21- An Acute Care Transfer form documented R444 as an unplanned transfer and that the guardian was notified. 1/4/21- An Ombudsman discharge notification form documented R444 was transferred on 1/3/21 for an acute medical event. 1/5/21 4:46 PM - E9 (SW) documented in a progress note that R444 was "Currently at hospital. NHA informed staff, not to re-admit R444 without (RDO) consent." Upon review of R444's record since the last annual survey on 6/23/21, R444 had been refused readmission to the facility with an a MDS assessment that documented discharge return anticipated. R444's record lacked evidence of the appropriate discharge documents. Review of the hospital's electronic referral system documented requests to the facility for readmission of R444 on the following dates: 6/28/21, 7/28/21, 8/12/21, 8/24/21, 9/21/21, 9/28/21, 10/27/21, 11/9/21, 11/16/21, 12/2/21, 12/9/21, 12/15/21, 1/4/22 , 1/18/22, 2/17/22, 2/23/22, 3/29/22 and 4/29/22. The record revealed the facility documented refusal of readmission for R444 as "No, negative history with patient." During an interview on 5/6/22 at 1:26 PM, E9 (SW) confirmed that the facility initiated a	F 626	patients who are discharged from the facility to the hospital to validate those patients are permitted to return to the facility after hospitalization and if there is an emergent transfer/discharge then the notice of transfer/discharge is provided, and the patient is able to reside in the facility while the appeal process is pending. Monitoring will be conducted weekly x 3 until 100% success consecutively is meet; then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	

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F 626	Continued From page 10	F 626		

discharge for R444 and that E9 was unaware of any plans to readmit the resident. E9 then stated, "I was told by my NHA at the time, do not take R444 back until it was discussed." On the same date during an interview at 1:43 PM, E9 confirmed the facility did not provide a discharge notice, discharge summary or care plan for R444's facility initiated discharge. E9 stated, "There is no letter because we were out of compliance at that time and we later had a survey and got a tag for not initiating the letter; there were no care plans sent because at the time we weren't sending them and doing the discharges right."

During an interview on 5/10/22 at 10:48 AM, RP1 (Public Guardian) confirmed that the facility did not readmit R444 and R444 was presently still in the hospital since January 2021. RP1 stated, "Yes, [R444's] still in the hospital, the facility said they would not take [R444] back and the Regional Director told [E9 (SW)] they would not accept [R444] back."

5/10/22 11:06 AM - The Surveyor requested the facility's discharge policy and readmission policy in use during R444's discharge. E2 (DON) reported the policies were unchanged from the current policies, but had different letter head. The facility changed ownership sometime after January 2021 when R444 was discharged from the facility.

During an interview on 5/10/22 at 12:13 PM, E13 (Admissions Coordinator) stated, "I believe [R444's] still at the hospital." When asked whether the facility intended to readmit R444, E13 stated, "Not that I'm aware of. I was instructed we were unable to meet his/her needs a while

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F 626	Continued From page 11 ago by the building and [former E14 (RDO)] at least a year ago." During a dual interview on 5/10/22 at 1:02 PM, E15 (RDO) was asked whether the facility had current plans to readmit R444. E15 stated, "I have not been contacted about that" and E2 (DON) stated, "No, I haven't heard of that." During an interview on 5/12/22 at 11:29 AM, E14 (former RDO), was asked if the facility intended to readmit R444 after sending the resident to the hospital. E14 responded, "I believe the discussion that we had was from a risk prospective and for the safety of other residents. The decision was [R444] needed inpatient psychiatric care and we could not provide that." E14 was then asked whether the hospital and responsible parties were made aware that R444 would not be readmitted to the facility. E14 stated, "I don't recall because I wouldn't have been involved in those communications. That would have been handled by the Administrator at the time and Social Worker who worked in the center [facility] itself... I was in frequent talks with the Administration over staff challenges, at some point [R444] was discharged to the hospital. We made a decision we could not accept [R444] back....". E14 was asked to confirm the note that documented on "1/5/21 4:46 PM NHA informed staff, not to re-admit [R444] without RDO consent." E14 denied knowledge of the note and stated, "I wanted to be included in any discussion because I didn't want to accept residents who could not be safely managed." During an interview on 5/16/22 at 12:00 PM with CM1 (hospital Care Manager), it was explained that, "We were made aware within the first twenty	F 626		

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F 626	Continued From page 12 four hours that the facility would not be taking the resident back. [R444] was admitted with agitation and we thought after stabilization of the symptoms he/she would return to the facility. Then they informed me [R444] would not be readmitted." CM1 confirmed it was E14 (RDO) who reported the facility would not be readmitting R444. CM1 reported there was no written documentation of the facility discharge and there has been no attempt by the facility to readmit R444 to the facility or to collaborate with the hospital. CM1 stated, "We have an electronic referral system, when we have submitted R444 to the facility (for readmission to the facility), they (the facility) send back a response of 'negative history with patient.'" Findings were reviewed with E2 (DON) on 5/10/22 at 1:15 PM.	F 626		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		6/30/22

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F 657	Continued From page 13 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that for two residents (R12 and R16) out of 39 sampled residents, the facility failed to review and revise the comprehensive person-centered care plan. Findings include: 1. Review of R12's clinical record revealed: 6/15/15 - R12 was admitted to the facility. 1/17/22 (last revised) - A care plan was initiated on 3/3/21 for "COVID-19 recovered, fully vaccinated." 1/25/22 - The "Patient Vaccination: Information Acknowledgement Form" documented that E4 (RN, UM) provided information and discussed the benefits for receiving the COVID-19 vaccine and that R12 refused the vaccine. 2/2/22 - The annual MDS indicated R12's BIMS score was 13 (able to independently make decisions regarding daily life). 4/11/22 - The "Patient Vaccination: Information Acknowledgement Form" documented that E4	F 657	It is the practice of the facility that all patient care plans are completed and revised timely. I Corrective Action R12s care plan was revised to properly record that R12 is not fully vaccinated and R12s care plan now states that patient is not fully vaccinated. R16s chronic kidney disease care plan was revised to reflect the intervention to encourage extra fluids during the day and evening shift. II Identification All current patients residing in the facility were reviewed to ensure that their vaccination status is properly recorded on their care plans. All current patients residing in the facility who have chronic kidney disease (CKD) Care Plans were reviewed to validate accuracy of interventions. III Systemic Changes Director of Nursing or designee will re-educate the nursing interdisciplinary team to ensure that care plans are completed and revised timely as it relates	

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F 657	Continued From page 14 (RN, UM) provided information and discussed the benefits for receiving the COVID-19 vaccine and that R12 refused the vaccine. 5/11/22 1:20 PM - During an interview, E16 (Infection Control Practitioner) provided written and verbal confirmation that R12 refused all COVID-19 vaccines. 5/11/22 4:00 PM - During an interview with E1 (NHA) and E2 (DON), it was confirmed that R12's care plan incorrectly included that she was fully vaccinated and had never received any COVID-19 vaccines. 2. Review of R16's clinical records revealed: 12/4/20 - R16 was admitted to the facility. 1/7/22 - A physician's order stated to encourage extra fluids during day and evening shifts as tolerated. 3/7/22 - A care plan for chronic kidney disease was developed and implemented, however, the above intervention to encourage extra fluids during day and evening shifts was not incorporated into this care plan or any of R16's care plans. 5/10/22 12:35 PM - An interview with E4 (RN UM) confirmed that the facility was unable to provide evidence that the above intervention was incorporated into R16's care plans. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 657	to the patients vaccination status and that interventions are accurately reflected on the care plan for patients with CKD. The root cause is a lack of execution of process as it relates to properly revising resident care plans as relates to vaccination status and interventions for patients with CKD. IV Monitoring Director of Nursing or designee will conduct random audits of all current patients who reside in the facility care plans to validate that patient□s accurate vaccination is reflected on the care plan. Director of Nursing or designee will complete random audits of all patients currently reside in the facility to validate those interventions are accurately reflected on the care plan for patients with CKD. Monitoring will be random audits weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	

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F 684	Continued From page 15	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to monitor if the fluid restriction was maintained for one (R388) out of four residents reviewed for hydration. Findings include: Review of R388's clinical record revealed the following: 4/20/22 - R388 was admitted to the facility for rehabilitation and was on hemodialysis due to kidney disease. 4/20/22 - A care plan was initiated for R388 for "Risk for alteration in hydration related to fluid restriction" with a goal of "Maintain adequate hydration." Interventions included, "Maintain fluid restriction as ordered." The total amount of fluid restriction and the amount allotted to dietary or nursing was not included in the care plan. 4/20/22 - A Physician's Order was written for a fluid restriction of 1,000 cc / day. 4/20/22 through 5/11/22 - Review of the	F 684	It is the practice that patients who reside in the facility with prescribed fluid restrictions are maintained. I Corrective Action R388 no longer resides in the facility. II Identification Current patients residing in the facility on a prescribed fluid restriction were reviewed and orders updated to include nursing and dietary allocation as additional directions. Nurse will initial acknowledgement of order with non-compliance documented in the clinical record. Patient□s care plan will be updated to include nursing and dietary allocations and triggered to Point of Care Kardex. III Systemic Changes The Director of Nursing or designee will re-educate licensed nurses on the facilities Hydration Management	6/30/22

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F 684	Continued From page 16 Treatment Administration Records revealed that licensed nursing staff only document that the fluid restriction was maintained every shift. There was no documentation of the amount of fluid allotted to nursing either in a day (24 hours) or in a shift. 4/20/22 through 5/11/22 - Review of the CNA documentation revealed that they only document "Hydration/Fluids Offered." There was no documentation of the amount of fluid allotted to nursing either in a day (24 hours) or in a shift (eight hours). 4/21/22 - The "Fluid Restriction Worksheet", completed by E17 (Registered Dietitian), allotted a total of 355 cc a day to dietary and 645 cc a day to nursing (divided by shift as 7 AM - 3 PM: 270 cc, 3 PM -11 PM: 275 cc, 11 PM -7 AM: 100 cc). 4/27/22 - The Admission MDS indicated R388's BIMS score was 14 (able to independently make decisions regarding daily life). 4/27/22 - A Physician's Order was written for a fluid restriction of 1,500 cc a day. 4/28/22 - The "Fluid Restriction Worksheet", completed by E17 (Registered Dietitian), allotted a total of 355 cc a day to dietary and 1145 cc a day to nursing (divided by shift as 7 AM -3 PM: 400 cc, 3 PM -11 PM: 400 cc, 11 PM -7 AM: 345 cc). 5/3/22 3:00 PM - During an interview, R388 stated that although he goes to dialysis three times a week, he was no longer on a fluid restriction. R388 stated, "Last week they [dialysis staff] told me I was dehydrated and took away my fluid restriction."	F 684	Guidelines specifically that patients on a prescribed fluid restriction have orders that include nursing and dietary allocation, non-compliance documentation in the clinical record, and care plan/Kardex updates with changes. IV Monitoring The Director of Nursing or Designee will audit 5 patients on a prescribed fluid restriction to validate the nursing and dietary allocations are included in additional directions and patient□s plan of care/Kardex, and validate any non-compliance is documented in the clinical record. Monitoring will be conducted weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	

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F 684	Continued From page 17 5/5/22 9:00 AM - During an interview, E17 (Registered Dietitian) explained that on 4/27/22 the dialysis staff sent a note back with R388 to increase his fluid restriction to 1,500 cc a day because he was dehydrated, so she completed another "Fluid restriction Worksheet." 5/5/22 9:40 AM - During an interview, E19 (UM, RN) confirmed that nursing staff do not keep track of exactly how much fluid R388 consumes. 5/5/22 10:00 AM - During an interview, E20 (LPN) stated that the nurses just eyeball how much fluid R388 takes with medications. "Since we only allow him to have sips with medications, we know he gets less than his fluid restriction. He has cranberry juice right now, but we don't write that down." 5/5/22 10:30 AM - During an interview, E22 (CNA) stated, "I just tell the nurse if he [R388] wants something to drink and what I gave him." 5/11/22 4:00 PM - During an interview with E1 (NHA), E2 (DON) and E19 (UM, RN), it was confirmed that the nursing staff and CNAs do not document the amount of fluid a resident on a fluid restriction consumes. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		6/30/22

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F 761	Continued From page 18 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R16) out of six (6) residents sampled for unnecessary medication review, the facility failed to properly label and store the medication. Findings include: Review of the facility's guidance, dated 11/17 and titled Medication Administration: Self-Administration of Medications, stated, "...Medications, if stored at the patient's bedside, are to be secured in a locked storage unit until use...". Review of the Lilly's manufacturer information for	F 761	It is the facility practice to properly label drugs and biologicals and store and manage in accordance with State and Federal Laws. I Corrective Action R16□s insulin pen was disposed immediately, and patient was educated on returning LOA medication upon return to the facility and R16□s care plan was updated to reflect education and intervention for patient to return LOA medication. II Identification Medication carts were audited to validate	

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F 761	Continued From page 19 the insulin (medication) documented, "...Throw away the Insulin Injection Pen you are using after 28 days...". Review of R16's clinical records revealed: 12/4/20 - R16 was admitted to the facility. 11/2/21 - A care plan for self administration of medication included an intervention that medications and supplies are maintained in a locked drawer at the bedside or in the medication cart. 5/10/22 1:25 PM - During an interview, R16 stated she self- administered her insulin when she was on leave of absence from the facility for part of the day, usually a few days per week and stores the insulin in her bag, which was kept in the closet in her room. The Surveyor observed the multiple dose insulin injection pen with a pharmacy delivery date of 12/8/21, however, it was unclear when the pen was initially used, as there was lack of evidence of an open date on the insulin pen. R16 stated that she was uncertain when the pen was initially used. 5/10/22 1:35 PM - An interview with E4 (RN, UM) revealed that she was not aware that R16 self administers her insulin when she was out of the facility on leave and confirmed the insulin pen lacked evidence when the pen was initially opened for use. E4 stated that she will discard the pen as there was no open date. In addition, E4 was uncertain if insulin had to be locked when not in use. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2	F 761	that multi-use insulin pens/vials are dated upon opening and discarded per manufacture guidelines. All current patients residing in facility to determine medication administration status and no other patients determined to self-administer medications. III Systemic Changes The Director of Nursing and/or designee will provide education to licensed nurses on Storage and Expiration Dating of Drugs, Biological, Syringes and Needles Procedure ensuring insulin pens are dated upon open and discarded per manufacture guidelines. Education will include opening insulin pen and dating when provided to patients for self-administration and/or leave of absence, and to retrieve any unused medications when patients return from a leave of absence. The root cause was a gap in the practice of the education of staff to validate that patient□s return unused medication when returning from a leave of absence. IV Monitoring Director of Nursing and/or designee will complete an audit of each medication cart to validate that multi-use insulin pens/vials are dated upon open and discarded per manufacture guidelines and patients who self-administer medications to validate those medications are retrieved when the patient returns from an LOA and/or self-administration. Monitoring will be conducted weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met.	

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F 761	Continued From page 20 (DON).	F 761	Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans. The results will be reviewed at the QAPI meeting monthly x 3 months.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R53) out of three residents reviewed for food preferences, the facility failed to accommodate R53's food preferences or choices. Findings include: 3/4/22 - R53 was admitted to the facility. 5/3/22 11:49 AM - During a dining observation, R53's hot tea was not included on the lunch tray despite her meal ticket showing hot tea for a	F 806	It is the practice that all patients who reside in the facility receive food of their preferences within the facilities provided food and beverage options. I Corrective Action Patient R53 meal ticket was updated to reflect patient□s preferences. II Identification All current patients residing in the facility	6/30/22

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F 806	Continued From page 21 beverage. 5/3/22 11:52 AM - In an interview with R53, it was revealed that R53 has a TPN feeding that runs overnight, but the resident is allowed to have a full liquid diet for breakfast, lunch and dinner. R53 stated, "I have requested to the CNA's, Nurses and the Dietitian that I want hot tea, cream of mushroom soup, cream of chicken soup, tomato soup and some grits. The facility has responded by telling me they will make a note of it, but every meal my tray has something wrong. They don't send my hot tea, they send me jello and puddings that I don't like despite that I let them know what I prefer to eat. When they send soup - most of the time it's not warm enough - it's cold that I had to ask the CNA's to warm it for me in the microwave. Sometimes the CNA's are not happy when I ask them to warm the food for me." 5/3/22 11:57 AM - E26 (CNA) delivered R53's lunch tray with no hot tea on the meal tray. R53 stated, "Tomato soup was warm, better this time, no need for heating in the microwave." The meal ticket indicated a hot tea for the beverage. R53 stated to the Surveyor "They said they will bring hot tea on my lunch tray, but there's none here, see that!" pointing at the tray which had no hot tea on it. 5/5/22 8:25 AM - R53 was observed having breakfast in her room and drinking her cup of tea. Her food tray had frozen yogurt, strawberry yogurt, cranberry juice, two big water cups, a cup of tea, a cup of hot water and a packet of hot chocolate. R53 stated, "It's not really the hot tea that I want, but I already had that conversation with (name of) the Dietitian. She said she will send it out hot from the kitchen, but not hot to	F 806	will be audited during a meal by reviewing tray accuracy to validate that the patient preferences are being met and if patient□s are not receiving their preferences the corrections will be made on the patient□s tray ticket by Dietary Director or designee. III Systemic Changes Administrator or designee will re-educate Dietary Staff to ensure that patient preferences on tray tickets are being honored. The root cause of the patient□s preferences being honored timeliness of updating patient□s ticket with changes to her preferences. IV Monitoring Administrator or designee will conduct random of audits of patient meal trays to validate patients trays to ensure accuracy of patient preferences. Monitoring will be conducted weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	

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F 806	Continued From page 22	F 806		

burn my tongue and I'm sure it will not be the same temperature when it lands on my table." R53 pointed at a bowl of food and it could not be determined if it contained a cream soup or cream of wheat. The meal ticket didn't specify what food was in the bowl. The ticket stated: "Special Instructions: Can have strained creamed soup, and cream of wheat." R53 stated, "I will not eat it, I don't know what's in it. That could be cream of wheat and they know very well that I don't eat cream of wheat because of the cinnamon that they add to it. It's not soup for sure!"

5/5/22 8:30 AM - During an interview with E26 (CNA), it was confirmed that R53 does not get her preferred food most of the time and E26 has to call the kitchen to get the foods that R53 likes. E26 stated that she "did not know what was in the bowl and it did not look like soup."

During an interview on 5/5/22 at 8:48 AM, E17 (RD) came and talked to R53. R53 explained to R17 about the "Wrong food on my tray, especially (pointing at) the bowl." R17 confirmed that the resident was receiving cream of wheat from the kitchen. The Surveyor heard R17 telling R53 "They sent you the cream of wheat? I will take this away and replace it. What do you want to eat? Do you want chicken broth?"

During an interview on 5/5/22 at 8:50 AM with E17 (RD), it was explained to the Surveyor that R53 had a diet change since last week to a full liquid diet. E17 confirmed that the resident disclosed a preference of eating grits and that cream of mushroom or cream of chicken soup were allowed. E17 confirmed the resident's preference for grits and that she doesn't want cream of wheat, she should not be getting cream

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F 806	Continued From page 23 of wheat and that her preference wasn't honored. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 806		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide special adaptive equipment, built-up grip utensils for one (R16) resident during a random meal observation. Findings include: Review of R16's clinical record revealed: 12/4/20 - R16 was admitted to the facility. 5/3/22 12:31 PM - During a random lunch observation, R16 was provided a meal with regular utensils. Review of R16's meal ticket on the tray documented "built-up spoon, fork, and knife." No built up spoon, fork and knife to consume the meal was provided to R16. 5/3/22 12:35 PM - An interview with E7 (LPN) confirmed that no built-up utensils were provided to R16. 5/9/22 (Most recent revision date) - CNA	F 810	It is the practice that residents who require special eating equipment and utensils are provided by the facility. I Corrective Action R16 was provided the built spoon, fork and knife. II Identification Patients who require special eating equipment and utensils are audited to validate that equipment is provided for meals. III Systemic Changes Administrator or designee will provide re-education to dietary staff on Adaptive Eating Devices Procedure to ensure that patients who are identified to receive special eating equipment and utensil are	6/30/22

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F 810	Continued From page 24 "Visual/Bedside Kardex Report" stated, "...Adaptive equipment: built-up grip utensils...". 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 810	provided for meals. The root cause was that the dietary staff were inconsistent when reading the tray ticket to provide assistive devices to patient who required assistive devices. IV Monitoring Administrator or designee will monitor patients who require special eating equipment and utensils are provided for meals. Monitoring will be conducted weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		6/30/22

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F 812	Continued From page 25 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide and store food in accordance with professional standards for food service safety. Findings include: The following was observed on 5/5/22 at approximately 9:05 AM during the initial kitchen tour: - The hand washing sink by the dish washer does not have a hand washing sign, - The water is pooling on the floor at the walk-in refrigerator below the condensor, - There was a container of moldy macaroni noodles. Findings were reviewed with E2 (DON) on 5/10/22 at 1:15 PM.	F 812	It is the practice of the facility that food is stored, prepared, distributed, and served food in a sanitary food service environment. I Corrective Action The hand washing sink by the dishwasher immediately received a hand washing sign. Water pooling on the floor in the walk-in was immediately cleaned. Container of moldy macaroni noodles was immediately disposed. II Identification The two hand washing sinks in the food service area will be audited to validate that hand washing signs are displayed properly. Sanitation Rounds to be completed in food service area to validate that floors are free from spills. Walk in-Refrigerator to be audited to ensure that all out of date/moldy food is disposed. III Systemic Changes	

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F 812	Continued From page 26	F 812	Administrator or designee will re-educate dietary staff on Hand Washing Procedure regarding hand washing signs at the hand washing sinks; Storage of Food Procedure specifically that out of date/moldy food must be disposed; and Sanitation Rounds Procedure that spills on floor must be cleaned. The root cause as a gap in knowledge of the dietary staff related to replacing signage above hand washing sinks, food storage and floors are free from spills. IV Monitoring Administrator or designee will monitor the food services area to ensure that the hand sinks have hand washing signs; spills on floor are cleaned and moldy food is disposed. Monitoring will be conducted weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		6/30/22

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F 842	Continued From page 27 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or	F 842		

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F 842	Continued From page 28 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other documentation as necessary, it was determined that for three (R26, R40 and R440) out of 39 sampled residents, the facility failed to ensure that medical records were accurate. Findings include: Review of R26's clinical records revealed the following: 1. R26 was admitted to the facility on 3/2/22. Review of March 2022 CNA documentation revealed that R26 was to have shower/baths done on Friday (days), Monday (evenings),	F 842	It is the practice of the facility patient medical records are complete, accurate documentation, readily accessible and systematically organized. I Corrective Action Patient R26 shower/baths are being documented. R40□s treatment order for gentamycin was immediately discontinued. R440 is no longer a patient at the facility. II Identification	

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F 842	Continued From page 29 Tuesday (days), Thursday (evenings) and as needed. "N/A" was written on 3/4, 3/8 and 3/11/22 for showers/baths. There was no documentation of a shower/bath until 3/15/22, 13 days after admission to the facility. 5/10/22 1:03 PM - E24 (CNA) who was assigned to R26, was asked during an interview what N/A meant when documented under shower/bath. E24 stated that she would not typically use N/A as there were other codes that were more applicable. 5/11/22 9:45 AM - During an interview with E4 (UM/RN) on the 2nd floor, E4 stated that N/A meant not applicable and that maybe the resident refused which should be an "R" instead of a N/A. After the dates were reviewed, E4 stated that R26 was in the rehab unit on the 1st floor at that time. 5/11/22 10:09 AM - During an interview with E19 (UM/RN) on the 1st floor, findings were discussed. E19 stated she would get the bed bath/shower sheets. 5/11/22 10:15 AM - E19 provided bed bath/shower sheets for 3/4, 3/8 and 3/11/22 that showed R26 received a bed bath on those dates. The CNA documentation for the above dates was inaccurate. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). 2. Observation of R40's pressure ulcer (PU) wound treatment and review of clinical records revealed the following:	F 842	All current patients residing in the facility shower/bath documentation will be reviewed to validate that shower/baths are being documented accurately. All new treatments orders for current patients with pressure ulcers residing in the facility for the previous week will be reviewed to validate that they were accurately transcribed. Late notes regarding falls for current patients who reside in the facility will be reviewed during the last 30 days to ensure that the late entry is documented appropriately. III Systemic Changes Director of Nursing or designee will re-educate current Certified Nursing Assistants on documenting showers/baths. Director of Nursing or designee will re-educate current licensed nurses on Clinical Documentation Guidelines specific to transcribing/notes and orders and late entry notes. The root cause for incorrect documentation of showers/baths is the related to the lack of execution of process in documentation expectations related to ADL and Care. The root cause is a gap in the execution of process as it relates to the transcription of treatment orders. The root cause is a gap in education in documentation principles for licensed nursing staff as it relates to late entries. IV Monitoring Director of Nursing or designee will complete a random audit of 10 current patient shower/bath documentation to ensure accuracy. Director of Nursing or	

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F 842	Continued From page 30 1/25/22 - R40 was admitted to the facility with multiple pressure ulcers including a PU of the sacrum. a. 5/5/22 - Review of the physician's order for the sacrum PU wound treatment included to apply gentamycin, an antibiotic ointment. 5/6/22 11:19 AM - An observation of the daily sacrum PU wound treatment performed by E4 (RN UM) was conducted and no application of gentamycin was observed. 5/6/22 11:50 PM - A post wound observation interview with E4 (RN UM) revealed that she was part of the facility's wound team and during the most recent weekly wound team rounds which occurred on 5/4/22, E4 recalled that the gentamycin ointment was to be discontinued. E4 provided the Surveyor the wound care team note that documented the gentamycin was to be discontinued beginning with the 5/5/22 wound care, however, the facility failed to revise the order. b. 5/5/22 - Review of the Treatment Administration Record (TAR) revealed that E6 (LPN) performed the sacral wound care, including the application of gentamycin. 5/6/22 11:50 PM - An interview with E4 revealed that she had spoken with E6 (LPN) and that E6 did not apply the gentamycin during the 5/5/22 sacral PU wound treatment; the clinical documentation was inaccurate. c. Review of the TAR for the 5/6/22 sacrum PU wound treatment observation contained initials of E6 (LPN) and not E4 (RN UM) who actually	F 842	designee will complete a random audit of all current patient who have pressure ulcers medical records will be reviewed to validate that treatment orders are accurately transcribed. Director of Nursing or designee will audit all current patients with falls will be reviewed to validate that notes that are late notes are properly identified. Monitoring will be conducted weekly x 3 until 100% success consecutively is met, then monthly x 2 until 100% success consecutively is met. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate up until monitoring at 100% success consecutively is met. The Quality Assurance and Performance Improvement Committee will determine the need for further monitoring and/or action plans.	

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F 842	Continued From page 31 performed the treatment. 5/6/22 1:00 PM - An interview with E4 confirmed that the above TAR inaccurately documented that E6 (LPN) performed the sacral PU wound treatment. 5/6/22 1:22 PM - A Progress Note by E4 (RN UM) stated that the sacrum dressing change was performed by E4 and was signed by E6 (LPN) in error. The facility failed to ensure the accuracy of R40's clinical record. 3. Cross refer F580. Review of R440's clinical records revealed the following: 7/26/16 - R440 was admitted to the facility. 6/6/18 - C1 became the court appointed guardian for R440. 2/7/22 - The facility's incident report stated R440 had an unwitnessed fall from the bed to the floor on 2/7/22 at approximately 11:30 PM and R440's family member (FM1) was notified on 2/8/22 at 12:30 AM. 2/7/22 23:30 PM - A Progress Note by E25 (RN) documented that R440 had swelling of her right foot and a physician's order was received for a cold compress and pain medication. 2/8/22 6:43 AM - A Progress Note by E5 (LPN) stated R440's family member (FM1) was notified of the unwitnessed fall.	F 842		

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F 842	Continued From page 32 2/8/22 10:56 AM - A Progress Note documented that the results of the x-ray of the left leg confirmed a fracture and an order was obtained to transfer R440 to the emergency room. The note documented that C1 was telephoned, however, there was no answer, thus, FM1 was telephoned and obtained approval to transfer R440 to the hospital. 5/11/22 1:43 PM - An interview with E5 (LPN) revealed for the 2/7/22 fall, she telephoned the court appointed guardian (C1), however, she was unable to contact C1, thus, proceeded to contact FM1, R440's son. The Surveyor informed E5 there was lack of evidence that an attempt was made to contact R440's guardian (C1). E5 stated that she completed a progress note afterwards to show that she attempted to contact C1. The Surveyor responded there was a Progress Note, dated 2/10/22 and timed 12:22 AM, stating, "Call first contact (Name of R440's court appointed guardian's name, C1), no answer." E5 stated this was the note related to the 2/7/22 unwitnessed fall, although there was no reference in the note to the 2/7/22 fall. The facility failed to ensure the accuracy of R440's clinical record by failing to document that the 2/10/22 12:22 AM Progress Note was a Late Entry related to a fall that occurred on 2/7/22. 5/12/22 3:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 842		